

SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS

☐ MR ☐ RD ☐ Autism ☐ TBI ☐ SCI ☐ SD ☐ Other

REQUEST FORM—INDIVIDUAL AND FAMILY SUPPORT STIPEND

Consumer: _____

Local Provider: _____

DSN/Home Board: _____

Local Provider Action

Received Date: _____

Review Date: _____

☐ Approved Amount: \$ _____

Approved Period: _____

☐ Denied (See reason below)

☐ No Action, Return to Referring Staff (See below)

Comments: _____

Local Provider Administrator

Date

DSN/Home Board If Different From Above

Received Date: _____

Review Date: _____

☐ Approved Amount: \$ _____

Approved Period: _____

☐ Denied (See reason below)

☐ No Action, Returned to Referring Staff (See below)

Comments: _____

DSN/Home Board Provider Administrator

Date

Provider Information

Referring Provider Staff: _____ Phone: (____) _____

Local Provider: _____

DSN/Home Board: _____

Consumer Information

Name: _____

Age/Birth Date: _____

Address: _____

Phone: (____) _____

Medicaid #: _____

SS#: _____

Number residing in household _____

Members of Household: Relationship/Age

Check All That Apply:

☐ DDSN Eligible

☐ HASCI Waiver Participation

☐ DDSN-Eligible High Risk

☐ CLTC Waiver Participation

☐ Medicaid Eligible

☐ Waiver Enrollment Pending

☐ Medicaid Eligibility Pending

☐ Waiver Waiting List - Critical

☐ MR/RD Waiver Participation

☐ Waiver Waiting List – Non-Critical

☐ Applying for DDSN services and requires interpreter services

Is the consumer currently employed? ☐ Full-time ☐ Part-time ☐ No

Monthly Household Income/Expense

(If additional space is necessary, attach worksheet to this form)

Income Sources

Amount

Major Expenses

Amount

Essential Expenses

Housing

Utilities

Food

Car Loans

Non-Essential Expenses

Loans

Credit Cards

Cable/Cell Phones

Recreational/Other

Total Monthly Income

(Attach copy of Income verification)

Total Monthly Expense

Net Balance (Income minus Expenses)

\$ _____

(Describe how Consumer's SSI Income is used)

I certify that the above consumer information is true and complete. I understand that submitting false information or use of Individual and Family Support Funds for purposes other than as requested may result in termination of assistance and a payback of expended funds to DDSN.

Consumer or Parent or Legal Guardian

Date

Request Information

Type Request

Amount Needed

Amount Requested

Approval Period

☐ One-Time

\$ _____

\$ _____

☐ Ongoing *

\$ _____

\$ _____

*(Provide detail information about costs of items requested.)

Service Category

☐ Assistive Technology/Assessment

☐ Medical Care/Allied Medical Care/Medical Supplies

☐ Personal Care Aide/Attendant Care

☐ Environmental Modification/Assessment

☐ Respite Care/Sitter Services

☐ Special Needs Child Care Cost

☐ Other (Specify) _____

Justification

Explain how out-of-home placement will be avoided unless request is for temporary funding while awaiting critical placement. Explain what the child/individual does during the day and if he/she is in school.

Assurance of Resource Review

Other resources utilized/contributed to assist with requested need:

☐ Consumer/Family

Amount \$ _____

☐ Private Insurance/Medicare/Medicaid

Amount \$ _____

☐ Private, Non-Profit (Specify) _____

Amount \$ _____

☐ Public Agency (Specify) _____

Amount \$ _____

☐ Social Security PASS (Plan for Achieving Self Support)

Amount \$ _____

☐ IRWE (Impairment Related Work Expense)

Amount \$ _____

☐ Other (Specify) _____

Amount \$ _____

Referring Provider Staff

Date

Reviewing Supervisor

Date